Do Not Staple!

KENTUCKY EMPLOYEES HEALTH PLAN

ENROLLMENT APPLICATION FOR THE JUDICIAL/LEGISLATORS RETIREMENT PLANS

PY 2009

Mail application to:

KY Judicial Form
Retirement System
305 Ann Street, Rm 302
Whitaker Bank Bldg.
Frankfort, KY 40601

INSURANCE COORDINATOR SECTION

☐☐ / ☐☐ / ☐☐☐☐
Coverage Effective Date

☐☐☐☐☐
Company Number

Reason for Application:

☐ < New Retiree ☐ < Open Enrollment ☐ < QE* ☐ < Previously Waived* ☐ < Other*

* If you previously waived, or marked "Other" or "QE" above, enter the Qualifying Event date _____ (Date) AND a description of the Qualifying Event: _____ (Qualifying Event Description)

SECTION I: DEMOGRAPHIC INFORMATION

Is retiree applying for this coverage? ☐ < Yes ☐ < No

If "No", what is your relationship to the retiree? ☐☐

☐☐☐ – ☐☐ – ☐☐☐☐
RETIREE SSN *(Required)*

_____
RETIREE Name (First, MI, Last)

☐☐☐ – ☐☐ – ☐☐☐☐
APPLICANT SSN (If retiree is not applying)

_____
APPLICANT Name (First, MI, Last)

APPLICANT Specific Information

_____
Mailing Address

☐☐ / ☐☐ / ☐☐☐☐
Date of Birth (MM/DD/YYYY)

_____ _____ _____
City, State, Zip Code | County of Residence | Country / Mail Code, if not USA

_____ _____ _____
Planholder's HOME Phone Number | Planholder's WORK Phone Number | Planholder's Email Address

Smoking Status *(Required)*

Have you smoked in the last 2 months? ☐ < Yes ☐ < No

Gender
☐ < Male
☐ < Female

Marital Status
☐ < Married
☐ < Single

SECTION II: PLAN ELECTION- If waiving (i.e. decline) health insurance coverage, go to Section IV.

1. Option (Check only one)	2. Level of Coverage	3. Cross-Reference Payment Option
☐ < Commonwealth Standard PPO	☐ < Single	**NOT APPLICABLE**
☐ < Commonwealth Capitol Choice	☐ < Parent Plus	
☐ < Commonwealth Optimum PPO	☐ < Couple	
	☐ < Family	

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION → *If you elected Single coverage, skip to Section VI*

Social Security Number	Name (First, MI, Last)	Gender (Circle one)	Date of Birth (MM/DD/YYYY)	Relationship Code
		M F		
		M F		
		M F		
		M F		

Relationship Codes: SP = Spouse, CH = Child, DD = Disabled Dependent, CO = Court-Ordered Dependent

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Retiree's SSN

			–			–					

Applicant's SSN (from Page1, Section I)

SECTION IV: WAIVER

Do you wish to waive (i.e. decline) your Health Insurance Coverage? ☐< Yes

SECTION V: FLEXIBLE SPENDING ACCOUNTS (FSA)

Not Applicable → **Retirees are not eligible to participate in a Flexible Spending Account**.

SECTION VI: AUTHORIZATION AND CERTIFICATION

* I understand that my signature on this application creates a legal and binding contract between myself, the Department of Employee Insurance and the TPA.
* I understand that each dependent I am enrolling meets the eligibility requirements of a dependent as set forth in the plan document and in the KEHP handbook.
* I understand that this plan has a tobacco incentive for members that do not use tobacco and that this plan offers tobacco cessation programs.
* I agree to abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
* I understand that the elections indicated on this application may not be changed or canceled during the plan year, with the exception of certain Qualifying Events.
* I authorize the Retirement System to deduct from my retirement benefits the amount required to cover my share of the coverage I have selected.
* I authorize the Retirement System to release the information in this application to the Social Security Administration. The information in this application may be used by the Social Security Administration to determine Medicare eligibility. I further acknowledge that Medicare eligibility may affect my participation in the Kentucky Employees Health Plan.
* I understand that the misrepresentation of any information on this application with the intent to defraud is a fraudulent insurance act, which is a crime, and any material misrepresentation or omission may be used to reduce or deny a claim or to terminate my coverage.
* I understand that each dependent I am enrolling meets the eligibility requirements of a dependent as set forth in the plan document and in the KEHP handbook.
* I have fully read the materials provided to me. My signature below certifies that the statements on this form are true and complete to the best of my knowledge.

_____ _____

Retiree Signature Date

_____ _____

Applicant Signature (if other than retiree) Date

_____ _____

Retirement Insurance Coordinator Signature Date